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Issue Date: 30 April 2007

In the Matter of:

L.K.,
Claimant

Case No: 2003-BLA-6133

v.

DOUBLE M COAL COMPANY, INC.,
Employer

RELIANCE INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Joseph E. Wolfe, Esq.
Wolfe, Williams & Rutherford
Norton, Virginia
For the Claimant

H. Ashby Dickerson, Esq.
Penn Stuart
Abingdon, Virginia
For the Employer/Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS ON REMAND

On March 8, 2005, I issued a Decision and Order Granting Benefits in this claim ("2005 Decision"). On appeal by the Employer, the Decision was affirmed in part and vacated in part, and the case was remanded by Decision and Order of the Benefits Review Board ("Decision and Order," "the Board"), BRB No. 05-0562 BLA, issued on March 16, 2006.

In its Decision and Order, the Board found that it was unclear which x-ray interpretations are part of the record, and vacated my findings pursuant to 20 CFR § 718.202(a)(1), that the positive readings are not sufficient to establish the existence of pneumoconiosis pursuant to § 202(a)(1). Upon remand, the Board ordered that I clarify which interpretations are properly admitted into the record and reevaluate the x-ray evidence. Decision and Order at 4.

The Board also vacated my findings regarding the medical opinion evidence, and directed that I evaluate each medical opinion to determine whether it is a reasoned medical opinion; avoid substituting my opinion for that of the physicians respecting evaluation of the objective tests; consider whether the Claimant has established the existence of either legal or clinical pneumoconiosis; and weigh all of the evidence regarding the existence of pneumoconiosis in compliance with *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). Decision and Order at 6.

In addition, the Board vacated my findings regarding the exertional requirements of the Claimant's usual work, and directed that I consider all of the relevant evidence, and the credibility of such evidence, before making a specific finding regarding the exertional requirements of the Claimant's usual coal mine employment. Decision and Order at 7.

Further, on the finding of disability, the Board remanded for further consideration of the blood gas study evidence and directed me to render conclusive findings on the issue of whether the blood gas study evidence demonstrates total disability pursuant to 20 CFR § 718.204(b)(2)(ii). Decision and Order at 8.

In view of the remand of my findings on the exertional requirements of the Claimant's coal mine employment, the Board also vacated my evaluation of the medical opinion evidence on the presence of a totally disabling pulmonary or respiratory impairment. On remand, I must consider each medical opinion to determine whether it is a reasoned and documented opinion, and weigh the opinions to determine whether they demonstrate a totally disabling respiratory or pulmonary impairment. In addition, I must weigh all of the contrary probative evidence together, like and unlike, to determine whether the Claimant has established total disability. Decision and Order at 8.

The Board also vacated my findings on the cause of the Claimant's pneumoconiosis, the cause of the Claimant's disability, Decision and Order at 9, and the date of onset of disability, remanding for reconsideration of all the relevant evidence on those issues.

The Board noted that certain of my findings were not challenged on appeal, including my findings that the Claimant had established a change in one of the applicable conditions of entitlement since denial of his prior claim; that the evidence does not establish the existence of pneumoconiosis pursuant to 20 CFR § 718.202(a)(2) (by means of biopsy or autopsy) or (a)(3) (by means of one of the presumptions found in 20 CFR §§ 718.304, 305, or 306); and that the evidence does not establish the presence of total disability pursuant to 20 CFR § 718.204(b)(2)(i) (by means of pulmonary function tests) or (iii) (by means of the presence of pneumoconiosis and cor pulmonale with right-sided congestive heart failure). Accordingly the Board affirmed those findings. Board Decision at 3 n. 3.

Upon receipt of the file on remand, I issued a notice to the parties and gave them 30 days to submit briefs. The Claimant and the Employer each submitted a brief. The record is now closed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Evidence Regarding the Exertion Required to Perform the Claimant's Last Coal Mine Job

The Claimant established 31 years of coal mine employment ending in 1995. DX 51, 6, 5. Over that time, he had many different jobs. The Claimant was not asked to describe in detail his last job in the mines at the hearing.[1] According to reports he filled out for OWCP, he was a shuttle car operator from October 1990 to August 1995. In response to the instruction to describe the duties of this job in his own words on the form in his current claim, he said, "Set on the machine and work levers—if we were broke down, I had to rock dust, shovel, work on the machinery." In response to an instruction to describe the physical activity required by the job, he marked sitting for 8 hours. DX 5. In response to the same question regarding his duties on the form in his previous claim, he said, "Haul coal from miner to belt feeder." As to physical activity, he marked sitting for 8 hours. He described the shuttle car as an electric powered car to haul coal with. DX 2 (DX 8). A different form was in use at the time of his first claim; the old form did not ask for similar information. DX 1.

The Claimant was also asked to describe his coal mine work by various doctors who saw him over the years. The evidence regarding his coal mine work reported by the doctors is described below.

I credit the Claimant's comment that his job as a shuttle driver required him to perform other tasks as needed. I cannot determine from the evidence before me just how much time he spent performing other tasks besides operating the shuttle, which constitutes essentially sedentary work. The tasks he described on the form do not meet the heaviest exertional requirements of some of the tasks he performed over the years and described to the doctors who examined him. Nevertheless, I find that rock dusting, shoveling and working on machinery, were all requirements of his job as a shuttle operator, and that the exertion required by all of those tasks exceeded the sedentary work of operating the shuttle.

Material Change in Conditions

This is the Claimant's third claim. His second claim was denied by an administrative law judge because although he found that the Claimant had established that he had pneumoconiosis, he had failed to establish that he was totally disabled due to pneumoconiosis. The Board left undisturbed my conclusion that the Claimant had shown a material change in conditions since denial of his prior claim. Decision and Order at 3, n. 3. However, my conclusion that the Claimant had established a material change in conditions was based on my finding that he was totally disabled by a pulmonary or respiratory impairment, a finding that was vacated by the Board. For the reasons discussed below, based on the arterial blood gas studies and the medical opinion evidence, I again conclude that the Claimant has established that he is totally disabled by

[1] His counsel did ask the Claimant whether all of his work was heavy work. Tr. at 30. Counsel for the Employer objected on the ground that the question was leading; counsel for the Claimant struck the question and answer. Tr. at 31.

a pulmonary or respiratory impairment. By so doing, the Claimant has also established a change in one of the applicable conditions of entitlement.

Medical Evidence

Chest X-rays

On appeal, the Employer challenged my weighing of the x-ray evidence because I considered a positive reading of the x-ray taken on September 30, 2002, by Dr. Rosenberg, whose examination report was offered into evidence by the Employer. Although the Employer designated Dr. Rosenberg's examination report on its Evidence Summary Form as one on which it relied, it did not designate his reading of the x-ray. In his report of the examination, Dr. Rosenberg disagreed with the negative reading by the Employer's other expert, Dr. Halbert, and relied upon his own reading, classifying the film as 1/0, to diagnose the presence of clinical pneumoconiosis. Setting aside the novelty of the Employer objecting to my consideration of a portion of its own exhibit, on which its expert relied in making his diagnosis, I am uncertain how to comply with the Board's remand instructions on the x-ray evidence. Each party is entitled to submit two x-ray interpretations in support of its case. The Claimant introduced only one positive reading in support of his case (Dr. Patel's reading of the x-ray taken April 3, 2003, CX 1), and designated Dr. Rosenberg's positive reading of the September 30, 2002, x-ray as the second x-ray interpretation on which he relied. *See* the Claimant's summary of the evidence, submitted at the hearing, at 7. I find nothing improper about the Claimant designating an x-ray interpretation by one of the Employer's experts. The Board did not state that I erred by considering Dr. Rosenberg's reading. However, the Board vacated my findings regarding the x-ray evidence, not because it was improper to consider Dr. Rosenberg's reading, but rather "[b]ecause it is unclear which x-ray interpretations are part of the record." The x-ray interpretations which I considered to be part of the record were listed in the 2005 Decision at pp. 5-7, and discussed at pp. 14-15. The x-ray interpretations which I did not consider to be part of the record were not listed, and were not discussed.

I will not reproduce the entire table showing x-ray results here, as there is no need to reiterate the x-ray evidence from the prior claims. As I stated in my 2005 Decision, the "great weight" of the x-ray evidence in the prior claims was negative for pneumoconiosis. That is, there were interpretations of 10 x-rays taken between 1975 and 1996 in the prior claims. Of those, 8 were read only as negative. Moreover, although there were two positive readings of the 1984 x-ray (by Drs. Kanwal and Gaziano), and one positive reading of the 1996 x-ray (by Dr. J.D. Sargent), there were three negative readings of both of those x-rays by other B readers, or dually qualified readers. Thus the overwhelming weight of the x-ray evidence in the prior claims was negative for pneumoconiosis.

From the current claim, I considered the x-ray readings appearing on the following table. Other x-ray readings offered by the Employer were excluded from evidence as exceeding the limitations contained in the regulations, and do not appear on the table. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis."

A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004). Any such readings are therefore included in the "negative" column. Qualifications of the reading physicians are listed after their names. "B" denotes a NIOSH certified B reader. "BCR" denotes a board certified radiologist.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/02/02[2]	DX 11 Forehand B ILO Classification 1/1	EX 3, DX 34 Scott B, BCR	DX 11 Navani B, BCR Read for quality only - Grade 2 Acceptable
09/30/02[3]	EX 1 Rosenberg B ILO Classification 1/0	EX 1 Halbert B, BCR	
04/03/03[4]	CX 1 Patel B, BCR ILO Classification 1/0	EX 6 Scott B, BCR	
09/23/03[5]		EX 4 Wheeler B, BCR	

To make more explicit my findings regarding the x-rays in the current claim, I find the x-ray dated May 2, 2002, to be negative, as Dr. Scott, who is dually qualified, is better qualified than Dr. Forehand, who is a B reader. I also find the September 30, 2002, x-ray to be negative, as Dr. Halbert is better qualified than Dr. Rosenberg, for the same reason. Thus my finding that this x-ray is negative would be the same, whether or not I consider Dr. Rosenberg's reading. I find the April 3, 2003, x-ray to be in equipoise, as Dr. Patel and Dr. Scott are equally qualified. I find the September 23, 2003, x-ray to be negative, as there is one negative reading, and no positive readings. Thus I find that the Claimant has failed to establish the presence of pneumoconiosis by virtue of the x-ray evidence. I also note, however, that a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986).

[2] This was the x-ray from the Department of Labor examination. The Employer designated Dr. Scott's reading in rebuttal. I excluded an additional reading by Dr. Scatarige, EX 2 and DX 34.2, offered by the Employer, because it exceeded the limitations contained in the regulations. The Claimant did not offer a re-reading of this x-ray.

[3] This was the x-ray from Dr. Rosenberg's examination of the Claimant on behalf of the Employer. In his summary of the evidence, the Claimant designated Dr. Rosenberg's reading as one of his two x-ray readings allowed in support of his case. The Employer designated Dr. Halbert's reading as one of its two readings.

[4] This was the x-ray from Dr. Rasmussen's examination of the Claimant performed at the request of his counsel. Dr. Rasmussen did not render his own reading of the x-ray taken as part of the examination; rather, he relied on the reading by Dr. Patel. The Claimant designated Dr. Patel's reading as the other of his two readings. The Employer designated the reading by Dr. Scott in rebuttal of Dr. Patel's reading. I excluded an additional reading by Dr. Scatarige, EX 5, as exceeding the evidentiary limits.

[5] This was the second x-ray reading relied upon by the Employer. I did not consider Dr. Dahhan's reading of the same x-ray found in EX 4, because the Employer designated Dr. Wheeler's reading as the one on which it wished to rely. The Claimant did not offer a rebuttal reading.

Pulmonary Function Studies

The record contains results of seven pulmonary function studies administered between 1984 and 2003. For a table showing the individual results, *see* the 2005 Decision at 7-8. All had normal results except for the tests administered in 1984 and 1995 by Dr. Kanwal, which he interpreted to show mild restrictive disease. That finding was never repeated in later studies by any physician.

Arterial Blood Gas Studies

As my finding that the Claimant established that he is totally disabled by a pulmonary or respiratory impairment is based in part on the results of arterial blood gas studies, I will reproduce the table with results of blood gas studies from all three claims here. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	**Date**	**Physician**	**pCO_2 at rest/ exercise**	**pO_2 at rest/ exercise**	**Qualify?**	**Physician Impression**
DX 1	05/28/86	Kanwal	38.6 37.5	75.8 84.7	No No	Hypoxemia noted.
DX 2 (DX 16)	10/24/95	Kanwal	45 44.1	80.1 84.1	No No	Near normal.
DX 2 (EX 21)	11/27/96	J. D. Sargent	38	69	No	Lower limits of normal for age.
DX 34	01/06/99	[Treatment]	41.8	67.5	No	pO_2 below reference range
DX 34	10/16/01	[Treatment]	44.0	65.4	No	pO_2 below reference range
DX 11	**05/02/02**	**Forehand**	**40** **42**	**62** **57**	**No** **Yes**	**Exercise-induced hypoxemia. Acceptable study per Dr. Michos.**
DX 34	09/09/02	[Treatment]	39.5	78.2	No	pO_2 below reference range
EX 1	**09/30/02**	**Rosenberg**	**41.1**	**75.9**	**No**	**Oxygenation preserved.**

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
CX 1	**04/03/03**	**Rasmussen**	**39.0** **39.0**	**63.0** **61.0**	**No** **Yes**	**Minimal resting hypoxia. Moderate impairment in oxygen transfer with exercise.**
EX 4	**09/24/03**	**Dahhan**	**41.9** **42.6**	**73.9** **84.7**	**No** **No**	

Medical Opinions

As my conclusion that the Claimant has established that he is totally disabled by a pulmonary or respiratory impairment due to pneumoconiosis is based on the medical opinion evidence, I will again summarize all of the medical opinion evidence in the record from all three claims.

Dr. G.S. Kanwal examined the Claimant on behalf of the Department of Labor on August 28, 1984, in connection with his first claim. DX 1. Dr. Kanwal is board eligible in internal medicine. DX 2 (DX 15). He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant had been working in the mines for 20 years, all inside work. He was still working as a mechanic at the time of the examination. He reported a smoking history of 1/2 pack per day for 5 years ending in 1964. The physical findings on the respiratory system are partly illegible, but indicate no rales or rhonchi. Dr. Kanwal read the x-ray as showing pneumoconiosis, category 1/1. The pulmonary function test was compatible with restrictive disease. The arterial blood gas study revealed hypoxemia. In the portion of the form for the diagnosis, Dr. Kanwal indicated that the physical examination results were within normal limits, but there was early radiological evidence of pneumoconiosis. He further indicated that it was related to dust exposure, but said the Claimant was not disabled and could do a hard job.

Dr. Kanwal again examined the Claimant on behalf of the Department of Labor on October 24, 1996, in connection with his second claim. DX 2 (DX 13). He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 30 years. His notes about the Claimant's jobs are handwritten, and difficult to read. It appears that he believed that the Claimant was required to lift 50 lbs.; that all of the Claimant's work was inside the mines; and that his jobs included miner, (?), supply car, general, (?), and "last Job—shuttle car operat[or]." DX 2 (DX 13 at 1). He reported a smoking history of 1/2 pack per day for 1 year 35 years ago. The chest examination revealed rhonchi. Dr. Kanwal read the x-ray as showing s/p opacities with a profusion of 0/1. The pulmonary function test showed mild restrictive pulmonary disease. The arterial blood gas study was near normal. Dr. Kanwal diagnosed shortness of breath on exertion, wheezing, and prolonged coal dust exposure. He said the Claimant's respiratory symptoms were related to coal dust exposure. As to the degree of severity, Dr. Kanwal said that the Claimant was symptomatic, with severity of mild degree. He said the pulmonary function and arterial blood gas parameters did not indicate disability, and

indicated that the symptoms "may" relate to coal dust exposure and other irritants in the mines. On February 28, 1996, the claims examiner for OWCP wrote to Dr. Kanwal to inquire whether the Claimant had coal workers' pneumoconiosis as defined by the act (reciting the definition), and whether it was caused by his coal mine employment. In his reply dated March 8, 1996, Dr. Kanwal checked "yes" to both questions, giving his rationale as follows:

> Pt [Patient] has prolonged coal dust exposure. He has respiratory symptoms. There is absence of significant smoking history—ABG [arterial blood gas] is noted. I feel in toto that Pt. has approx 15-20% respiratory disability related to coal dust exposure.

DX 2 (DX 14).

Dr. J. Dale Sargent examined the Claimant on behalf of the Employer on November 27, 1996, also in connection with his second claim. DX 2 (EX 21). Dr. Sargent is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 31 years. He said the Claimant's last job as a shuttle car operator required him to "sit on a piece of equipment and operate controls. It would not require a lot of manual labor." DX 2 (EX 21 at 3). Other work history included logging, a machine shop and an insulation plant. He reported a smoking history of 1/2 pack per day for two years, quitting 35 years ago. The lungs were clear to auscultation and percussion. Dr. Sargent read the x-ray as showing simple coal workers' pneumoconiosis of profusion 1/0, p/p. The pulmonary function test was normal. The arterial blood gas study was at the lower limits of normal for his age. Dr. Sargent diagnosed simple coal workers' pneumoconiosis based on the x-ray findings. He found that the Claimant retained the respiratory capacity to perform his last or any other job in the mines. He said that the lack of a ventilatory impairment was the rule rather than the exception given simple pneumoconiosis of very low profusion.

Dr. J. Randolph Forehand examined the Claimant on behalf of the Department of Labor on May 2, 2002, in connection with his current claim. DX 11. Dr. Forehand is board-certified in allergy and immunology, and pediatrics, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 29 years, all underground, performing jobs of foreman, shuttle car operator, miner and bolt machine, as reflected on his work history form. Dr. Forehand did not comment on the exertional level of the work. He reported a smoking history of 1/2 pack per day from 1955 to 1960. The chest examination revealed crackles at the right base. Dr. Forehand read the x-ray as showing s/t opacities in both middle and lower zones, with a profusion of 1/1. The pulmonary function test was normal. The arterial blood gas study revealed hypoxemia with exercise, no metabolic disturbance. Dr. Forehand diagnosed coal workers' pneumoconiosis due to coal dust exposure, based on the Claimant's history, physical examination and arterial blood gas study. In his opinion, the Claimant had a significant respiratory impairment of a gas-exchange nature, with insufficient oxygen-transfer capacity remaining to return to his last coal mine job. He said coal workers' pneumoconiosis was the sole factor contributing to the respiratory impairment, as the Claimant's five-year history of smoking was not enough to impair lung function.

Dr. David Rosenberg examined the Claimant on behalf of the Employer on September 30, 2002. EX 1. Dr. Rosenberg is board-certified in internal medicine, pulmonary disease, and occupational medicine, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, electrocardiogram, blood gas studies and pulmonary function testing. He also reviewed readings of x-rays taken between 1975 and 2002; pulmonary function tests from 1984, 1995, 1996, and 2002; blood gas studies from 1984, 1995 and 1996; and records from the evaluations by Dr. Kanwal, and the evaluations by Dr. J.D. Sargent in 1996, and by Dr. Forehand in 2002. Dr. Rosenberg reported the results of the x-rays, pulmonary function tests, arterial blood gases, and other records he reviewed. As to his own examination, he reported a smoking history of 1/2 pack per day for 5 years. He reported that the Claimant worked in the mines for 30 years ending in 1995. He said the Claimant's last job as a shuttle car operator "didn't involve much lifting, but just moving various levers on the train in order to load and [unload] coal." EX 1 at 6. Other work over the years included various jobs. The Claimant occasionally wore a mask, but not on a regular basis. Other work outside the mines did not involve any particular dust exposure. The chest examination was normal. As to the x-ray, he noted that Dr. Halbert, a radiologist, read the x-ray as showing no interstitial opacities, but he read it as showing p/s changes in all lung fields, except the left upper, with a profusion of 1/0. The pulmonary function test was normal, without evidence of obstruction or restriction. Diffusing capacity corrected for lung volumes was normal. Dr. Rosenberg said that the Claimant's "oxygenation status was generally preserved." EX 1 at 6. No exercise blood gas study was administered because of the Claimant's history of angina. He characterized the Claimant's smoking history as "minimal."

Dr. Rosenberg said that the Claimant's total lung capacity was normal, indicating no restriction. Lung fields were clear, without chronic rales. Diffusing capacity was normal, indicating intact alveolar capillary bed, "confirmed by a previous exercise test which demonstrated normal gas exchange."[6] EX 1 at 7. Although Dr. Halbert found the x-ray to be negative for micronodularity, Dr. Rosenberg thought category 1 changes were present. The FEV_1% was normal, indicating no chronic obstructive pulmonary disease. Dr. Rosenberg said it would be unlikely that any current cough or sputum production related to inhalation of coal dust which stopped many years before. Dr. Rosenberg noted that the Claimant was receiving treatment for coronary artery disease, unrelated to inhalation of coal dust. Dr. Rosenberg diagnosed simple coal workers' pneumoconiosis without associated impairment. Dr. Rosenberg found that the Claimant retained the respiratory capacity to perform his last job in the mines, or other similarly arduous work.

Dr. Donald L. Rasmussen examined the Claimant at the request of his counsel on April 3, 2003. CX 1. Dr. Rasmussen is board-certified in internal and forensic medicine, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, pulmonary function testing, and an electrocardiogram. He reported that the Claimant worked in the mines for about 32 years. Dr. Rasmussen reported that the Claimant worked in a saw mill for two to three years, and a machine shop for a year. He described the Claimant's coal mine work as follows:

[6] Dr. Rosenberg did not specify which exercise study he was referring to. Review of his report discloses that he recited the results from exercise blood gas studies administered in 1984 and 1995 (*see* EX 1 at 3), but not the result from Dr. Forehand's study (*see* EX 1 at 3, 5). He did, however, note that Dr. Forehand observed "exercise-induced hypoxia." EX 1 at 5.

> The patient was employed in the coal mining industry between 1956 and 1995 for a total of about 32 years. He was a hand loader, cutting machine operator, roof bolter, continuous miner operator, section foreman, mechanic. His last job was that of shuttle car operator. He shoveled the tail piece. He loaded and unloaded supplies. He rock dusted lifting 50# rock dust bags. He set timbers when pillaring. He shoveled the belt. Thus, he did considerable heavy and some very heavy manual labor.

CX 1 at 2. Dr. Rasmussen did not distinguish among which of the Claimant's jobs involved the heavy and very heavy manual labor he described. Dr. Rasmussen reported a smoking history of 1/2 pack per day for five years from 1957 to 1962. The chest examination revealed moderately reduced breath sounds, with no rales, rhonchi, or wheezes. He relied on Dr. Patel's reading of the x-ray which indicated pneumoconiosis s/s with a profusion of 1/0 throughout the middle and lower lung zones. The electrocardiogram was within normal limits. The pulmonary function test was normal. Maximum breathing capacity was normal. Single breath carbon monoxide diffusing capacity was normal. The arterial blood gas study revealed minimal resting hypoxia, with moderate impairment in oxygen transfer with exercise. Dr. Rasmussen went on to state:

> These studies indicate at least moderate loss of lung function as reflected by his impairment in oxygen transfer during exercise. He does not retain the pulmonary capacity to perform his last regular coal mine job with its requirement for significant heavy manual labor.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has coal workers' pneumoconiosis which arose from his coal mine employment.
>
> The only risk factor for this patient's disabling lung disease (considering his brief smoking history) is his coal mine dust exposure. The pattern of impairment is quite consistent with coal mine dust induced lung disease …
>
> The finding of a normal single breath diffusing capacity does not exclude impairment in oxygen transfer during exercise. … The patient's coal mine dust exposure is the cause of his disabling lung disease.

CX 1 at 3 (Citations omitted).

Dr. A. Dahhan examined the Claimant on behalf of the Employer on September 24, 2003. EX 4. Dr. Dahhan is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He also reviewed readings of x-rays taken between 1975 and 2002; pulmonary function tests from 1984, 1995, 1996 and 2002; arterial blood gases from 1984, 1995, 1996, 1999, 2001, and 2002[7]; and reports by Dr. Kanwal, Dr. Sargent, Dr. Forehand, and Dr. Rosenberg. Dr. Dahhan reported that the

[7] Dr. Dahhan listed the blood gas study results at rest and after exercise from 1984 and 1995. All of the other blood gas studies he listed were at rest only. EX 4 at 3-4. He did not list any results from Dr. Forehand's tests, although he did note Dr. Forehand's conclusions. EX 4 at 3. He apparently did not see Dr. Rasmussen's report.

Claimant worked in the mines for 31 years ending in 1995, with his last job being as a shuttle driver. Dr. Dahhan did not comment on the exertional level required for that job. He reported a smoking history of one pack per day for five years ending in 1962. The chest examination was normal. Dr. Dahhan's x-ray reading was excluded from the exhibit as the Employer chose to rely on the re-reading by Dr. Wheeler which appears on the chart above. Tr. at 26. The pulmonary function test was normal. He recited the results of the arterial blood gas studies with rest and after exercise, but did not characterize the significance of the results. Dr. Dahhan concluded:

> 1. There are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the normal clinical examination of the chest, adequate blood gases at rest and after exercise, normal spirometry, lung volumes and diffusion capacity and negative x-ray reading for pneumoconiosis.
>
> 2. [The Claimant] has no evidence of pulmonary impairment and/or disability …
>
> 3. From a respiratory standpoint, [the Claimant] retains the physiological capacity to continue his previous coal mining work or job of comparable physical demand …

EX 4 at 4.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no biopsy or autopsy evidence. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

As noted above, I have found the x-ray evidence to be negative for pneumoconiosis, and thus the Claimant has failed to establish the presence of pneumoconiosis by virtue of the x-ray evidence. I must next consider the medical opinion evidence. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the

physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). In accordance with the instructions from the Board, I have considered whether the medical opinions are documented and reasoned, and whether they support a finding of either clinical or legal pneumoconiosis.

Dr. Kanwal, who is board eligible in internal medicine, examined the Claimant twice, in 1984 and 1996. Dr. Kanwal took relevant histories, conducted physical examinations, and performed objective tests. He was of the opinion that the Claimant had pneumoconiosis. Based on the results of his first examination, including an x-ray which he read to be positive for pneumoconiosis, 1/0, Dr. Kanwal opined that there was early radiological evidence of pneumoconiosis, but said that the Claimant was not disabled. After his second examination, including an x-ray which he read to be 0/1, Dr. Kanwal found that based on the Claimant's respiratory systems, his prolonged coal dust exposure, and the absence of a significant smoking history, that the Claimant had a respiratory impairment of 15-20% due to coal dust exposure, but he still was not disabled by it. Dr. Kanwal's initial diagnosis, based on a positive x-ray, apparently constituted a diagnosis of clinical pneumoconiosis. The fact that I have found the x-ray evidence to be negative, however, undermines his initial diagnosis. His second diagnosis, on the other hand, was not based on a positive x-ray reading; nonetheless, he still believed the Claimant to have coal dust induced disease. I find that both opinions by Dr. Kanwal were documented and reasoned. While Dr. Kanwal did not distinguish between clinical and legal pneumoconiosis, I find his opinion to be probative that the Claimant had pneumoconiosis within the meaning of the Act and the regulations.

Dr. Sargent, who is a board certified pulmonologist, also examined the Claimant in 1996. He, too, took relevant histories, conducted a physical examination, and performed objective tests. He was also of the opinion that the Claimant had early simple pneumoconiosis, based on an x-ray he read to be positive, 1/0. Dr. Sargent did not distinguish between clinical and legal pneumoconiosis, but his reference to "simple" pneumoconiosis suggests that he considered only clinical pneumoconiosis. I find his opinion to be documented and reasoned, but it is undermined by my finding that the x-ray was negative. Nonetheless, in view of his excellent qualifications, I give his opinion some weight on the issue.

Dr. Forehand, who is board certified in allergy and immunology, and pediatrics, examined the Claimant in 2002. Although he is not a pulmonologist, I credit Dr. Forehand with expertise in diagnosing pneumoconiosis, as he is a NIOSH qualified B reader, and he is on the Department of Labor's list of qualified examiners. *See* DX 10. He took relevant histories, and conducted a physical examination and objective testing. Dr. Forehand found the x-ray taken in connection with his examination to be positive, 1/0. He did not distinguish between clinical and legal pneumoconiosis, and to the extent his opinion rested on the positive x-ray reading, it is undermined by my determination that the x-ray was negative. However, he also based his diagnosis on the presence of a lung impairment, and thus I construe his opinion to encompass both legal and clinical pneumoconiosis. I find his opinion to be documented and reasoned. I also give his opinion probative weight on the issue of whether the Claimant has pneumoconiosis.

Dr. Rosenberg, who is a board certified pulmonologist, also examined the Claimant in 2002. He took relevant histories, and conducted a physical examination and objective testing.

He had the opportunity to review Dr. Rosenberg read the x-ray taken in connection with his examination as positive for pneumoconiosis, category 1/1. Although he was aware that Dr. Halbert had read it to be negative, he specifically disagreed. Dr. Rosenberg diagnosed simple coal workers' pneumoconiosis without associated impairment. I interpret his use of the term "simple" to mean that he diagnosed only clinical pneumoconiosis. He did not comment on legal pneumoconiosis. I find his opinion to be documented and reasoned, as it was consistent with most of the other physicians but, again, it is undermined by my finding that the x-ray he relied upon was negative. Moreover, Dr. Rosenberg found no lung impairment of any kind, without addressing any of the contrary findings by other physicians. Thus his credibility is undermined by his failure to acknowledge the existence of any lung impairment, despite evidence to the contrary in the records he reviewed. Because his view that the Claimant has pneumoconiosis was consistent with most of the other physicians on this issue, however, I give his opinion some weight on the presence of pneumoconiosis.

Dr. Rasmussen examined the Claimant in 2003. Dr. Rasmussen is board certified in internal and forensic medicine. Although he is not board certified in the sub-specialty of pulmonary disease, according to his CV, Dr. Rasmussen undertook a one-year residency in pulmonary diseases as part of his medical training; is a Senior Disability Analyst and Diplomat of the American Board of Disability Analysts; and has performed considerable consulting work and published articles regarding miners and black lung disease. CX 1. Dr. Rasmussen relied on Dr. Patel's positive reading of the x-ray taken as part of his examination in diagnosing pneumoconiosis, and emphasized the positive x-ray in reaching his determination that, given the Claimant's significant history of exposure to coal mine dust, "[i]t is medically reasonable to conclude that [he] has coal workers' pneumoconiosis." This portion of his report seems to be referring to clinical pneumoconiosis. However, he also reported an abnormal chest examination, minimal resting hypoxia, and moderate impairment in oxygen transfer with exercise. He said that the Claimant was disabled, and went on to state that "[t]he only risk factor for this patient's disabling lung disease (considering his brief smoking history) is his coal mine dust exposure. The pattern of impairment is quite consistent with coal mine dust induced lung disease …" Hence, although Dr. Rasmussen did not distinguish between clinical and legal pneumoconiosis, I find his opinion to be sufficiently broadly based to encompass both, i.e., that the Claimant had pneumoconiosis within the meaning of the Act and the regulations.

Finally, Dr. Dahhan, a board certified pulmonologist, also examined the Claimant in 2003. He, too, based his opinion on histories, physical examination and objective testing, and review of the records from all of the black lung claims up to and including Dr. Forehand's and Dr. Rosenberg's 2002 reports. Dr. Dahhan found insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the normal chest examination adequate blood gases, normal spirometry, lung volumes and diffusion capacity, and a negative x-ray. Dr. Dahhan also found no evidence of any pulmonary impairment. As his conclusions were supported by his own findings, I find his report to be documented and reasoned to that extent. However, despite the fact that he had access to all of the medical reports up to Dr. Forehand's, Dr. Dahhan did not address or explain the contrary findings by all of the other physicians who examined the Claimant. Thus I find that his opinion is entitled to less weight.

After weighing all of the medical opinions of record, I resolve the conflict in the evidence by according the greatest probative weight to the opinions of Drs. Forehand and Rasmussen. Although neither has the specialist qualifications possessed by Dr. Dahhan, I find their reasoning

and explanations in support of their conclusions more complete and thorough than that provided by Dr. Dahhan. Drs. Forehand and Rasmussen better explained how all of the evidence they developed supported their conclusions. I also find the opinions of Drs. Forehand and Rasmussen to be in better accord both with the evidence underlying their opinions, and the overall weight of the medical evidence of record. Further, additional credibility is lent to their findings that the Claimant has pneumoconiosis by the positive diagnoses of Drs. Rosenberg, Sargent and Kanwal. All of the physicians who examined the Claimant diagnosed him to have pneumoconiosis except Dr. Dahhan. Thus the weight of the medical opinion evidence supports a finding of pneumoconiosis.

In addition, I must also weigh the x-ray and medical opinion evidence together. As the regulations allow, I conclude that the well reasoned and documented medical opinions outweigh the negative x-ray readings, as the former are based on thorough clinical evaluations and objective testing. Thus I find that the Claimant has established that he has pneumoconiosis within the meaning of the Act and the regulations based on the medical opinion evidence.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for 31 years, and therefore is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption. Moreover, to the extent that Claimant has legal, as opposed to clinical pneumoconiosis, the causal relationship is established by the opinions of Drs. Kanwal, Forehand and Rasmussen. I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

None of the pulmonary function studies submitted in connection with any of the Claimant's claims meet the standards for disability contained in the regulations. Indeed, all of the tests since 1996 have been characterized as normal. Therefore, total disability cannot be established pursuant to Section 204(b)(i), either considering only the studies submitted with the current claim, or considering all the available studies.

While none of the resting arterial blood gas studies yielded values qualifying to establish disability, two out of three exercise blood gases submitted in connection with the current claim did produce qualifying values. The exercise blood gas studies in evidence in the prior claims, on the other hand, did not produce qualifying values. I give little weight to the studies in the prior claims, as they are remote in time, and therefore less likely to reflect the Claimant's current condition.

The record of the current claim includes seven arterial blood gas studies, three from treatment, and four from examinations conducted in connection with the claim. All three studies from treatment, taken in 1999, 2001 and 2002, reflect oxygen values below the reference range. These studies were introduced into evidence without any accompanying treatment notes or any explanation of their significance. Nor do they contain the information required by 20 CFR § 718.105(c). For these reasons, I give them little weight.

Dr. Forehand administered both a resting and an exercise study. The exercise study resulted in a value qualifying for disability. Dr. Michos, a board certified pulmonologist, validated the study. The study complies in all respects with the requirements of 20 CFR § 718.105(c). I give Dr. Forehand's study probative weight on the issue of disability.

Dr. Rosenberg conducted only a study at rest. It did not result in a qualifying value. I give it little weight, because he did not conduct an exercise study.

Dr. Rasmussen also administered both a resting and exercise study. The exercise study resulted in a qualifying value. The study complies in all material respects with the requirements of 20 CFR § 718.105(c). It has not been independently validated, but neither has it been invalidated. I also give Dr. Rasmussen's study probative weight on the issue of disability.

Finally, Dr. Dahhan also administered both a resting and exercise study. Neither study resulted in a qualifying value. The study complies in all material respects with the requirements of 20 CFR § 718.105(c). It has not been independently validated, but neither has it been invalidated. I also give Dr. Dahhan's study probative weight on the issue of disability.

Two out of three of the recent exercise blood gas studies resulted in qualifying values. I give the greatest weight to Dr. Forehand's May 2002 study, which contains all of the information required by 20 CFR § 718.105(c), and has been independently validated. The studies taken during treatment, which I infer to be resting studies, did not meet the requirements of the regulation, and did not result in qualifying values. Nonetheless, as they showed results below the reference range for normal, they also support an inference that the Claimant has an impairment in oxygen transfer. I find that the preponderance of the arterial blood gas study evidence supports a finding of disability.

As to the medical opinions, Dr. Kanwal was the first to find a pulmonary or respiratory impairment. He did so based upon relevant histories, physical examination and objective testing. His opinions were consistent with the evidence available to him. I therefore find his opinions on disability to be documented and reasoned. He did not find the Claimant to be disabled at the time of either examination (1984 and 1996). At the time of his first examination, the Claimant was still working in the mines, as a mechanic. Dr. Kanwal's second examination took place the year after the Claimant left the mines. Dr. Kanwal noted that the Claimant's last job was that of shuttle car operator. He reported that the Claimant was required to lift 50 lbs. I conclude that the Claimant told him that lifting 50 lbs. was a requirement of his job as shuttle car operator. Because the report was very close in time to when the Claimant was still working, and consistent with his later report found in his work history form, DX 5, as well as his report to Dr. Rasmussen, I find that it was a credible report of the job of shuttle car operator as he actually performed it. As Dr. Kanwal found only a mild impairment based on the objective testing, including a "near normal" blood gas results, which included an exercise study, his conclusion that the Claimant was not disabled as of 1996 was supported by the evidence then available.

Dr. Sargent's opinion on disability was also based on and consistent with histories, physical examination and testing, and thus a documented and reasoned opinion. He noted that the Claimant's resting blood gas study was at the lower limits of normal for his age, while his pulmonary function test was normal. Dr. Sargent said that the Claimant's last job as a shuttle car operator involved sitting on equipment and operating controls, and "would not require a lot of manual labor." I do not find this description to exclude the 50-lb. lifting requirement, or the other tasks I have credited the Claimant with performing while he was a shuttle car driver. In any event, Dr. Sargent said that the Claimant retained the respiratory capacity to perform any job in the mines. Thus the demands of the particular job the Claimant performed had no effect on his assessment that the Claimant was not disabled. Although Dr. Sargent did not perform an exercise blood gas study, Dr. Kanwal's nearly contemporaneous study did not qualify to show disability. I find that Dr. Sargent's opinion was also supported by the evidence then available, including both the evidence he developed, and the evidence as a whole.

Although I have found both Dr. Kanwal's and Dr. Sargent's opinions that the Claimant was not disabled as of 1996 to be well documented, reasoned, and supported by the evidence, I also find that their opinions on the issue of disability are entitled to little weight when considered with the evidence as a whole, as they were remote in time.

All of the opinions on the issue of disability given in the current claim were based on histories, physical examinations and objective testing. In the case of Drs. Rosenberg and Dahhan, each had access to additional medical evidence as well. Thus I find that all of the medical opinions in the current claim are documented. Drs. Forehand and Rasmussen found the Claimant to be disabled, while Drs. Rosenberg and Dahhan did not.

Dr. Forehand found that the Claimant was disabled due to his significant impairment in gas exchange. Dr. Forehand did not comment on the exertion required by the Claimant's last job. Rather, his opinion was based on the qualifying exercise blood gas study. As it is supported by the objective evidence, I find that his opinion is entitled to probative weight on the issue of disability.

Dr. Rosenberg found that the Claimant had no lung impairment. Dr. Rosenberg did not administer an exercise blood gas study. Although he had access to Dr. Forehand's report, he said that the Claimant had normal gas exchange, confirmed by an exercise test. Dr. Rosenberg did not specify which exercise test he was referring to. It appears, however, that Dr. Rosenberg overlooked or ignored the results of Dr. Forehand's qualifying exercise test, which was administered only four months before Dr. Rosenberg's examination; the most recent, non-qualifying exercise test before that was administered by Dr. Kanwal in 1995, seven years earlier. Dr. Rosenberg did not offer any reason for disregarding Dr. Forehand's results. As Dr. Rosenberg's opinion that the Claimant had normal gas exchange was inconsistent with the objective evidence available to him, I find that his opinion was not well reasoned, and give his opinion little weight on this issue.

Dr. Rasmussen found that the Claimant was disabled by his lung impairment. He characterized the Claimant's regular coal mine job as requiring "significant heavy manual labor." His description of the Claimant's work, quoted above at p. 10, is ambiguous as to whether he was referring only to the Claimant's job as a shuttle car driver, or whether he was describing the exertion required to perform all of the Claimant's jobs over the years that he worked in the mines. Considering the evidence as a whole, however, Dr. Rasmussen's description of "considerable heavy and some very heavy manual labor" appears to overstate the exertion required by the Claimant's job as a shuttle driver, even taking into account the other tasks besides operating the shuttle I have found he was required to perform. Nonetheless, Dr. Rasmussen's finding of a disabling gas exchange impairment is also supported by the qualifying exercise blood gas study. For this reason, I give probative weight to his opinion that the Claimant is disabled.

Finally, Dr. Dahhan also found no lung impairment. He administered an exercise blood gas study which did not result in qualifying values. Thus, his opinion was reasoned to the extent that it comported with his own test results. However, like Dr. Rosenberg, Dr. Dahhan reviewed Dr. Forehand's report, but did not list the results of Dr. Forehand's exercise study with the other blood gas results he considered. Nor did he offer any reason to discount Dr. Forehand's results, or any explanation for the different results he himself obtained. For these reasons, I find that Dr. Dahhan's opinion is entitled to less weight on this issue.

Considering all of the medical opinion evidence together, I find that the opinions of Drs. Forehand and Rasmussen that the Claimant is disabled, outweigh the contrary opinions of Drs. Kanwal, Sargent, Rosenberg and Dahhan. The opinions of Drs. Kanwal and Sargent, although supported by the evidence available at the time they were formed, are out-of-date. The opinions of Drs. Rosenberg and Dahhan fail to address the qualifying blood gas study obtained by Dr. Forehand. They were not aware that Dr. Rasmussen also obtained qualifying values with exercise. Drs. Forehand and Rasmussen better explained how all of the evidence they developed supported their conclusions. The opinions of Drs. Forehand and Rasmussen are in better accord both with the evidence underlying their opinions, and the overall weight of the medical evidence of record. I find that the preponderance of the medical opinion evidence supports a finding of total disability.

Finally, weighing like and unlike evidence together, the preponderance of both the qualifying blood gas study evidence, and the medical opinion evidence, support a finding of total disability. Although the pulmonary function tests did not result in qualifying values, I note that

they do not contradict the blood gas studies, as they measure a different aspect of lung function. Moreover, I find that the qualifying arterial blood gas studies support the conclusion that the Claimant was disabled without regard to the exertion required by his job as a shuttle car operator. I find that the Claimant has established that he is totally disabled by a pulmonary or respiratory impairment based on the exercise blood gas studies, and the medical opinion evidence.

Causation of Total Disability

The current regulations state that unless otherwise provided, the burden of proving a fact rests with the party making the allegation. 20 CFR § 725.103 (2006). The Benefits Review Board has held that Section 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990). The cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006).

In this case, I have credited the opinions of Drs. Forehand and Rasmussen that the Claimant is totally disabled. Dr. Forehand said that pneumoconiosis was the sole factor contributing to the Claimant's respiratory impairment, as the Claimant's five-year history of smoking was not enough to impair lung function. Dr. Rasmussen agreed that coal dust exposure was the only risk factor for the Claimant's disabling lung disease because his smoking history was brief. All of the doctors who examined the Claimant obtained consistent histories regarding the Claimant's smoking, a maximum of five pack years ending in the 1960's, and the length of his coal mine work, about 30 years of coal mine employment by the time he left the mines in 1995. I find that both doctors gave documented and reasoned reports regarding the cause of the Claimant's disabling lung disease. Their opinions are also supported by Dr. Kanwal's documented and reasoned report in 1995, that the Claimant had a non-disabling respiratory impairment due to prolonged coal dust exposure.

Drs. Sargent, Rosenberg and Dahhan did not give any opinion as to the cause of the Claimant's lung impairment, as they thought he had no impairment. For this reason, I have not considered their opinions in reaching my determination on this issue.

I find that the Claimant has established that his disability was caused by coal workers' pneumoconiosis based on the opinions of Drs. Forehand and Rasmussen, supported by the opinion of Dr. Kanwal.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date.

Owens v. Jewell Smokeless Coal Corp., 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his current claim on January 7, 2002. The earliest arterial blood gas study resulting in a value qualifying for disability was administered by Dr. Forehand on behalf of the Department of Labor on May 2, 2002. Thus the Claimant was already disabled by the time of Dr. Forehand's examination. I have found that the opinions of Drs. Rosenberg and Dahhan that the Claimant is not disabled, and the non-qualifying exercise blood gas study by Dr. Dahhan, are outweighed by other evidence. Thus the evidence does not show that the Claimant was not totally disabled at any time after May 2002.

I find that the Claimant became entitled to benefits the month his claim was filed, January 2002.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he has pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus the Claimant has met his burden of showing a change in an applicable condition of entitlement pursuant to § 725.309(d). Accordingly, the Claimant is entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2006). On August 4, 2005, I issued a Supplemental Decision and Order Granting Attorney Fee for services rendered to the Claimant from March 19, 2003, through March 14, 2005. The Claimant's attorney has not yet filed an application for attorney's fees for any time period after March 14, 2005. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees accruing after March 14, 2005. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on January 7, 2002, is hereby GRANTED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).